

treatment before considering epidural spinal cord stimulation. But it is clear that patients prefer the totally implantable system. TENS systems are bulky, cumbersome, and skin reactions are common. Dr Colquhoun's arguments are similar to those put forward when the external Lucas pacemaker system was used. That was also much cheaper but it was displaced by totally implantable pacemaker systems. There are problems with the present epidural electrodes which slip too frequently; but with further developments it should be possible to overcome these, and we are now trying new designs.

It is not our experience that all forms of electrical neurostimulation are equally effective. Some patients respond better to TENS than epidural stimulation and vice versa. For this reason we now insert a temporary electrode that can remain in place for 2-3 weeks to assess effectiveness before we implant the permanent unit; this also ensures that an expensive unit is not implanted unnecessarily.

Finally, I was interested in Dr Colquhoun's comments about the optimal frequency of stimulation and the work by Han. We have tried stimulating at 15 Hz and it seems to be effective but some patients describe it as a rather unpleasant sensation compared with higher frequency stimulation. But this subject is in its infancy (in the West) and there is much to explore about mechanisms and the best techniques.

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Limited potential of special ambulance services in the management of cardiac arrest

SIR,—We agree with Dr Rowley and colleagues that there has not been sufficient critical analysis of the effectiveness of ambulance personnel with advanced training (*Br Heart J* 1990;64:309-12). However, we wish to make the following observations about their findings and raise important questions about the development of the emergency ambulance service.

Concentration on those patients with pre-hospital cardiac arrest brought to the accident and emergency department excludes an unknown number of resuscitation attempts terminated by attending doctors. It may be that crews with defibrillator training spend more time at the scene of an arrest, increasing the likelihood that a general practitioner will arrive, certify that the patient is dead, and release the ambulance. The basic emergency crew will "scoop-and-run", leaving less scope for GP involvement. This may explain why larger numbers of patients were transported to hospital by the crews with a more basic training. What were the total number of resuscitation attempts made by each type of crew, regardless of later hospital transfer?

In our area ambulances only transport victims of cardiac arrest to hospital if resuscitation is in progress. When resuscitation is inappropriate a doctor is called to certify death and the patient is left at the scene or taken to the mortuary. We were surprised therefore that 64 of 147 patients were taken to hospital by defibrillator trained crews without any attempt at resuscitation. These patients had not been pronounced dead by a medical

practitioner. What criteria did the ambulance personnel use to withhold resuscitation from these individuals?

While the conclusion that the addition of other skills (drug administration and intubation) might save "a few extra lives" is probably correct, we are concerned that this study together with the results of the Scottish experience of semiautomatic defibrillators¹ may stop full extended training in ambulance aid being given to paramedics.

We have already shown the effectiveness of personnel with extended training in the management of hypoglycaemic coma.² There is recent evidence that patients with acute myocardial infarction complicated by hypotension and bradycardia have a better outcome when transported to hospital by a paramedic vehicle rather than an ordinary ambulance.³ Personnel with extended training also treat patients with acute asthma,⁴ hypovolaemic shock, and respiratory arrest, and in the future may administer thrombolytic agents.⁵

We are sure that the provision of a defibrillator on every emergency ambulance is an essential short term aim for improving the prehospital management of cardiac arrest. We are equally certain that the provision of a paramedic on every vehicle, coupled with a strict clinical audit, is the essential long term approach to improving all aspects of pre-hospital emergency care.

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- 1 Cobbe SM, Redmond MJ, Hollingworth J, Carrington DJ. Heartstart Scotland: initial experience of a nationwide scheme for out of hospital defibrillation by ambulance crews [Abstract]. *Br Heart J* 1990;64:65.
- 2 Weston CFM, Stephens MR. Hypoglycaemic attacks treated by ambulance personnel with extended training. *BMJ* 1990;300:908-9.
- 3 Pressley JC, Severance HW, Raney MP, et al. A comparison of paramedic versus basic emergency medical care of patients at high and low risk during acute myocardial infarction. *J Am Coll Cardiol* 1988;12:1555-61.
- 4 Wathen CG, Crompton GK, Carrington DJ, Hollingworth J. Treatment for acute asthma in the ambulance [Letter]. *Br J Gen Pract* 1990;40:388.
- 5 Bouten MJM, Simoons ML, Pool J, Hartman JAM. Prehospital thrombolysis by ambulance paramedics [Abstract]. *Eur Heart J* 1989; 10(suppl):123.

BOOK REVIEW

Practical Echocardiography in the Adult. J P M Hamer. (Pp 229; £79.50.) Dordrecht, The Netherlands: Kluwer Academic Publishers, 1990. ISBN 0792306708.

There are many large detailed reference texts for those experienced in echocardiography and Doppler. However, there is a dearth of books, like this one, giving practical advice and tips to those starting and learning the technique.

The book is approximately 200 pages long

and liberally illustrated with high quality diagrams and echocardiographic/Doppler images. Unfortunately, many of the images and Doppler recordings have been reproduced in a rather small format and this does not do them justice. Dr Hamer has attempted to cover every aspect of adult echocardiography and with each cardiac structure he has described what features the echocardiographer should examine and what measurements to make. This is indeed good practical advice and to my knowledge is not presented in this form elsewhere.

In discussing each abnormality Dr Hamer has very sensibly integrated the role of all the echocardiography and Doppler techniques including transoesophageal echocardiography. There is also a small but excellent chapter on reporting echocardiograms which I believe would be of particular value to non-clinicians.

There is undoubtedly a need for practical books on echocardiography and I am sure that this volume will prove popular. However, while the range of topics covered is very comprehensive this has unfortunately caused a lack of detail and omission of many practical pointers which those new to the technique would have undoubtedly found useful.

MARK J MONAGHAN

BRITISH CARDIAC SOCIETY NEWSLETTER

The office move was completed uneventfully, and we now have more space. At present the society occupies three rooms at the top of numbers 1 and 2 St Andrew's Place, and we hope to have the fourth room shortly. We can now accommodate committee meetings, and once we have a large enough table (we hope second hand) full council meetings should also be possible in our own premises. Please note that our address is Number 1. We have given up one telephone number but now two lines are available on 071-486 6430.

The Glasgow meeting is approaching. We have made one more break with tradition in that we are liaising with our public relations consultants to encourage the presence of the media. Our constitution states that the press will not be admitted to scientific sessions, and this will be upheld. But we plan to offer briefing sessions where we will be prepared to discuss items of interest that are expected to be presented that day, and to comment on items that may have been presented on the previous day. This will of course be conditional on agreement with the authors. We hope that the senior author or a nominee will agree to be present if we know that a particular paper is likely to attract interest. The health and medical correspondents of the London daily newspapers may not wish to travel to Glasgow. If necessary we may be able to arrange a meeting in London beforehand with an embargo on any premature publication. Particular care must be taken not

to encourage or indeed permit detailed publication in the lay press of scientific data that should first appear in medical journals. We believe that there may be enough interest in general discussion of topics that are of legitimate public interest. This is being tried as an experiment, and experience will show whether or not there is good reason to repeat it. Another initiative we plan with the media will involve occasional lunch time meetings with one or two correspondents. Their principal purpose is to establish contact which will aid liaison in the future rather than to seek publicity over current issues.

We consulted the Royal College of Physicians over the title for the new post of specialist career advisor. The suggestion of Postgraduate Dean might, it was felt, cause confusion with Regional Postgraduate Deans. We have therefore accepted advice that Howard Swanton should be known as Postgraduate Cardiology Advisor. We hope that members of the society or indeed others seeking a future in cardiology will consider consulting him if they need specialist information that can supplement the help they will receive from Regional Postgraduate Deans: we do not seek to duplicate a service that is already available and of proven value.

Members of the society should now be aware of the need to register completion of specialist training in cardiology with the General Medical Council, although the entry will show only T(M) for general medicine. Many currently in consultant posts did not have the opportunity to become accredited because the scheme did not exist during their training years. For an interim period all who have been appointed to a consultant post with the agreement of a representative of one of the medical Royal Colleges can obtain registration. This clause should embrace all who hold National Health Service contracts at consultant level. Those wishing to take advantage of the "grandfather clause" (the name was invented by one more considerably distinguished than ourselves) should write to the registrar of the college and should receive in return a copy of a formal letter to the General Medical Council. We suggest you take this action without delay.

A meeting was held at the Royal College of

Physicians in February for National Health Service managers entitled "New Approaches in Cardiology". The programme was arranged by Michael Petch. The topic of heart transplants led to a lively discussion, especially on cost implications. Other presentations dealt with thrombolysis, angioplasty, electrical treatments, training, and academic cardiology. This was a useful meeting. We do not do as much as we should to give our administrators the background information they need. The increase in the cost of pacemakers (modest we hope) that will almost certainly occur because of the closer financial ties with Europe from 1992 was news to many. A show of hands indicated that few had been warned of this by their local cardiologists. That seemed a good indication of a failure of communication that is worth pondering. Perhaps some cardiologists are not aware that harmonisation (which is the appropriate jargon word) will bring some financial penalties?

Two health authorities have been told by the National Health Service Executive that they may not readvertise senior registrar posts when they fall vacant. Three posts are involved. This has been brought to our attention only in the last week or so, though one letter was received in December. There was a clear implication that these particular changes, needed in order to meet imposed quotas, were agreed at a JPAC review in consultation with the specialty. This is not so. The Royal College of Physicians, the Specialist Advisory Committee, and the British Cardiac Society were all unaware of the action that had been taken. Our numbers are approximately correct by the formula of the Joint Planning Advisory Committee, but may not take account of the arbitrary 20% "top slice" removed from our allocation for the research pool (which is not specialty specific). We have disputed the need and the logic of this curious system that may underlie these recent cuts. We believe that any action to cancel a senior registrar post should be the subject of negotiation with the specialty, and we hope that the National Health Service Management Executive will have second thoughts about the wisdom of actions taken without appropriate consultation. "Achiev-

ing a Balance" can be made to work effectively only if a spirit of cooperation is maintained. We have striven to play our part. If any readers know of further actions of this type we would like to know without delay.

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NOTICES

1991

The Annual Meeting of the **British Cardiac Society** will take place at the Scottish Exhibition Centre, Glasgow on 30 April to 3 May. The closing date for receipt of abstracts was 10 December 1990.

XVIII Argentine Congress of Cardiology will be held in Buenos Aires on 18 to 21 September: Sociedad Argentina de Cardiología, Azcuénaga 980, 1115 Buenos Aires, Argentina (Fax: +54-1-961 6020; Tel: +54-1-961-6027/29).

12th international symposium on Computer Assisted Decision Support and Database Management in Anaesthesia, Intensive Care and Cardiopulmonary Medicine will be held in Rotterdam on 2 to 4 October: Dr Omar Prakash, Thorax Anaesthesia, Thorax Centre, Erasmus University, 3000 DR Rotterdam, The Netherlands (Fax: 31-10-463 5240; Tel: 31-10-463 5230).

1991 Pfizer international research symposium on Epidemiology of Peripheral Vascular Disease will be held in Edinburgh on 31 October and 1 November: Clare Perry, Edinburgh Post-Graduate Board for Medicine, Pfizer Foundation, 11 Hill Square, Edinburgh EH8 9DN (Tel: 031 650 2610).